MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC

Requestor's Name and Address SAN ANTONIO ORTHOPAEDIC SURGERY CENTER 400 Concord Plaza Suite 200 San Antonio, TX 78216	MDR Tracking No.: M4-04-0964-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address **Rep Box 19** GREAT AMERICAN ALLIANCE INSURANCE c/o Flahive, Ogden & Latson PO Drawer 13367 Austin, TX 78711	Date of Injury: Employer's Name: Garcia Labor Company Insurance Carrier's No.: 706 503003

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
02-03-03	02-03-03	29873 LT	$4,727.10	$1954.89
02-03-03	02-03-03	29877 LT	$6,668.00	$0.00
02-03-03	02-03-03	29881 LT	$6,668.00	$619.21
			Total Amount Paid:	(-$2070.90)
			Remainder Due:	$503.20

PART III: REQUESTOR'S POSITION SUMMARY

Requestor's Rationale for increased reimbursement or refund submitted on the TWCC 60 indicates, "Not paid fair and reasonable. September 17, 2003 letter from Requestor to the Carrier indicated, "…Accordingly, we are not in agreement with your stated position and are requesting that the entire amount reduced for such contention be paid…"

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's bill analysis company stated, "The recommended allowance reflects fair and reasonable fees in the geographic area where services were rendered. A consistent methodology has been applied to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement. Level of service provided by the facility was determined by review of relevant billing documentation and careful analysis of medical services actually performed by the practitioner. Fair and reasonable facility fees were calculated from a database that includes a local geographic wage index that has been validated by comparison to multiple published databases..."

The carrier's representative Position Statement indicated, "The billing in dispute has been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code. The provider must therefore prove that the reimbursement received is not fair and reasonable… Because Requestor has failed to prove that the reimbursement received is not fair and reasonable, Requestor is not entitled to further reimbursement. The Carrier otherwise requests a refund of any amounts previously paid in excess of the rate determined to be fair and reasonable…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

After reviewing the documentation provided by both parties, it appears that neither party has provided convincing documentation that sufficiently discusses, demonstrates, and justifies that their purported amount is a fair and reasonable reimbursement (Rule 133.307). After reviewing the services, the charges, and both parties' positions, it is clearly evident

that some other amount represents the fair and reasonable reimbursement.

During the rule development process for facility guidelines, the Commission had contracted with Ingenix, a professional firm specializing in actuarial and health care information services, in order to secure data and information on reimbursement ranges for these types of services. The results of this analysis resulted in a recommended range for reimbursement for workers' compensation services provided in these facilities. In addition, we received information from both ASCs and insurance carriers in the recent rule revision process. While not controlling, we considered this information in order to find data related to commercial market payments for these services. This information provides a very good benchmark for determining the "fair and reasonable" reimbursement amount for the services in dispute.

To determine the amount due for this particular dispute, staff compared the procedures in this case to the amounts that would be within the reimbursement range recommended by the Ingenix study (from 192.6% to 256.3% of Medicare for this particular year-2003). Staff considered the other information submitted by the parties and the issues related to the specific procedures performed in this dispute. Based on this review, staff selected a reimbursement amount in the low end of the Ingenix range. Medicare CCI edits were applied and CPT code 29877 is considered by Medicare to be a component procedure of code 29881 and 29873 with no modifier allowed and will not be reimbursed separately. In addition, the reimbursement for the secondary procedure was reduced by 50%, consistent with standard reimbursement approaches. The total amount was then presented to a staff team with health care provider billing and insurance adjusting experience. This team considered the recommended amount, discussed the facts of the individual case, and selected the appropriate "fair and reasonable" amount to be ordered in the final decision.

Based on the facts of this situation, the parties' positions, the Ingenix range for applicable procedures, and the consensus of other experienced staff members in Medical Review, we find that the fair and reasonable reimbursement amount for these services is $2,574.10. Since the insurance carrier paid a total of $2,070.90 for these services, the health care provider is entitled to an additional reimbursement in the amount of $503.20.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **$503.20.** The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

		8/5/05
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005 should be aware of changes to the appeals process, which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____